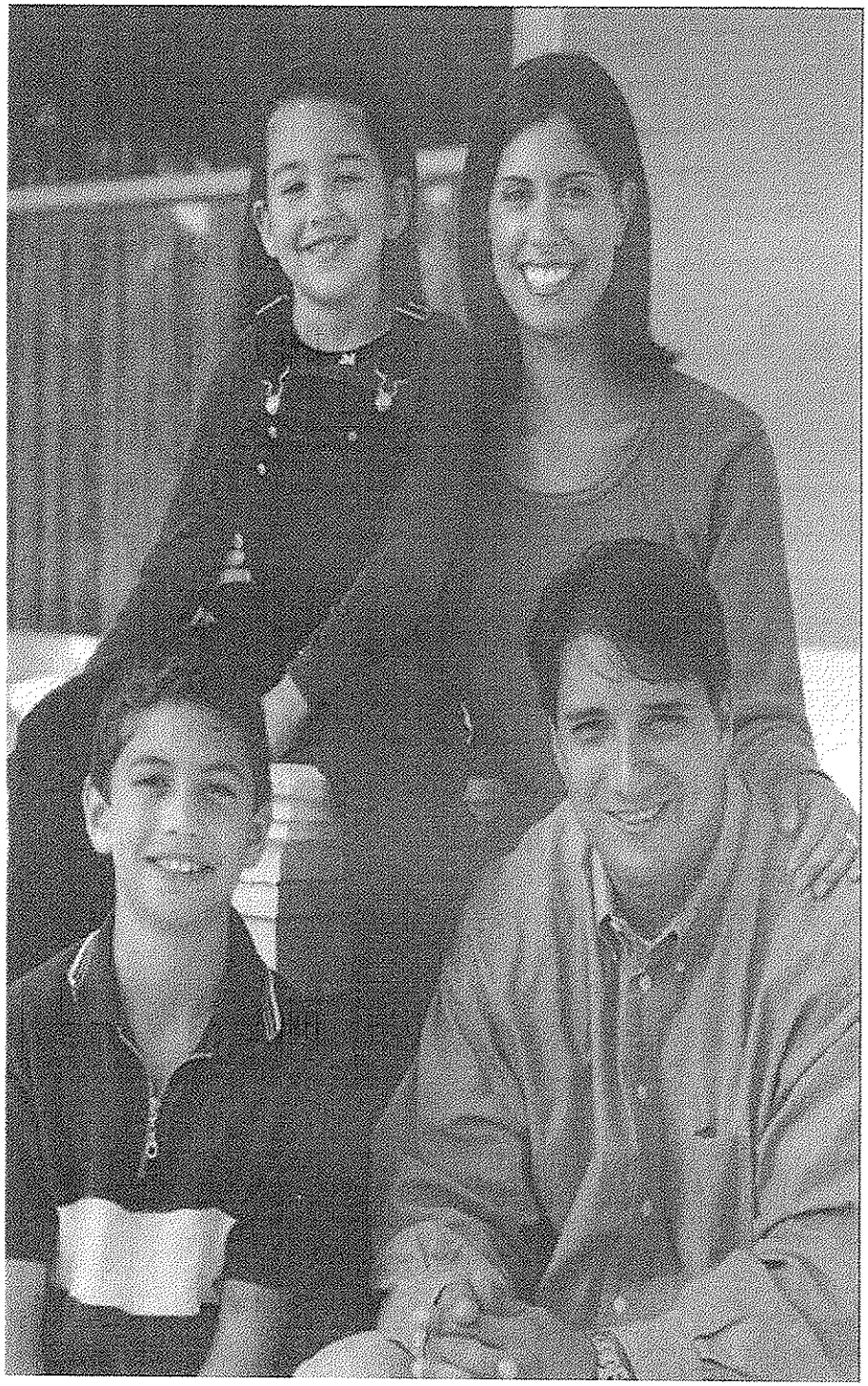


MCM Commission

Nick Toumpas

NH Department of Health and Human Services

New Hampshire MCM MEDICAID CARE MANAGEMENT

December 4, 2014

Legislative Office Building

Agenda

- Monthly Enrollment Update
  - MCM Step 1
  - NH HPP
- Key Program Indicator Report Update
- Step 2 Update
  - Phases and Timeline
  - Concepts
  - Next Steps
- Waiver Updates
  - Premium Assistance Waiver
  - Transformation Waiver
- Q&A from Commission and Public

Setting the Context

Care Management Program

December 1, 2013 – December 1, 2014

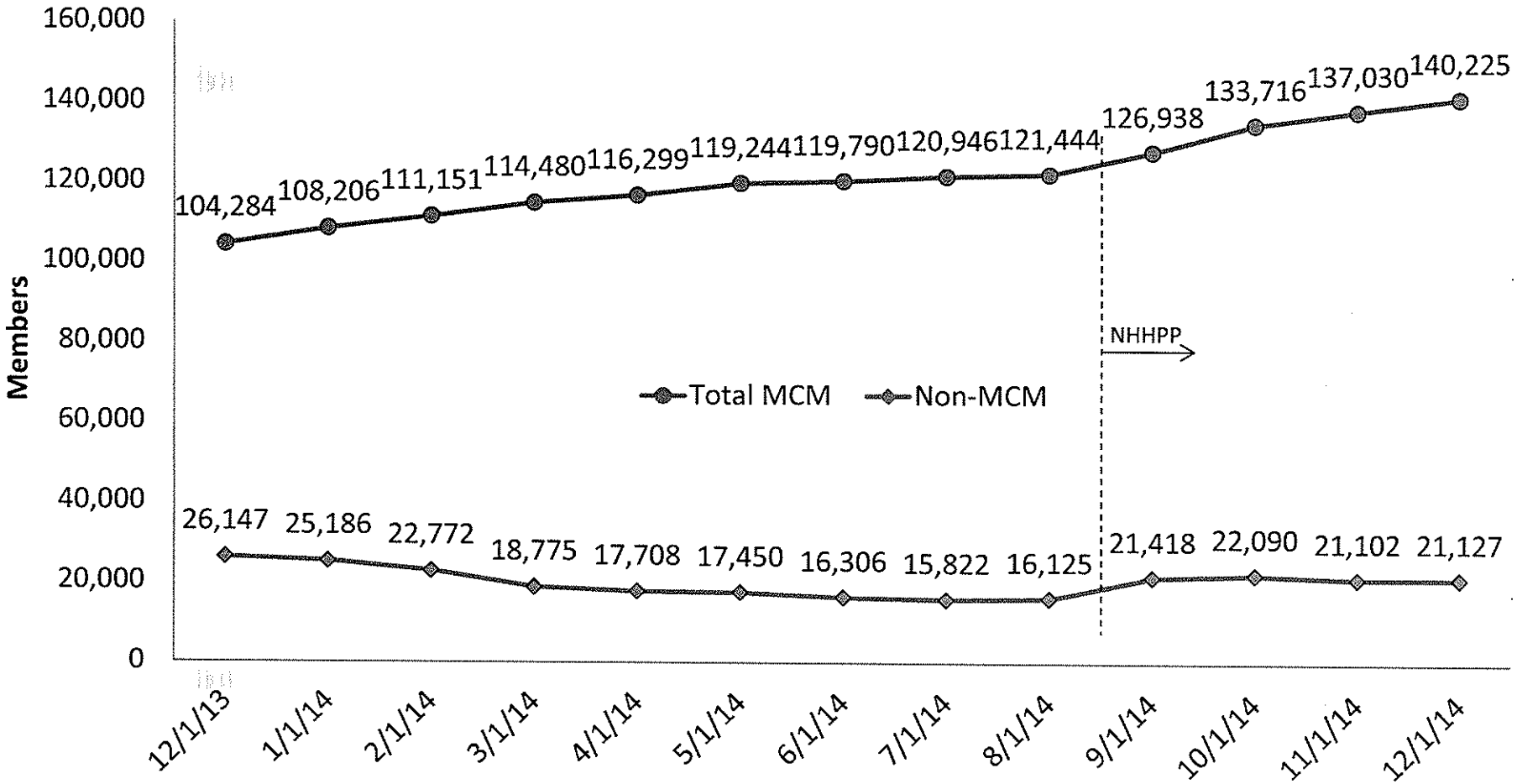
@ 1 Year

Guiding Principles of NH MCM

- Whole person management and care coordination
  - Foundation for Medicaid transformation
- Increase quality of care – right care, at the right time, in the right place to improve beneficiary health and quality of life
- Payment reform opportunities
- Budget predictability
- Purchasing for results and delivery system integration

MCM Monthly Enrollment Update

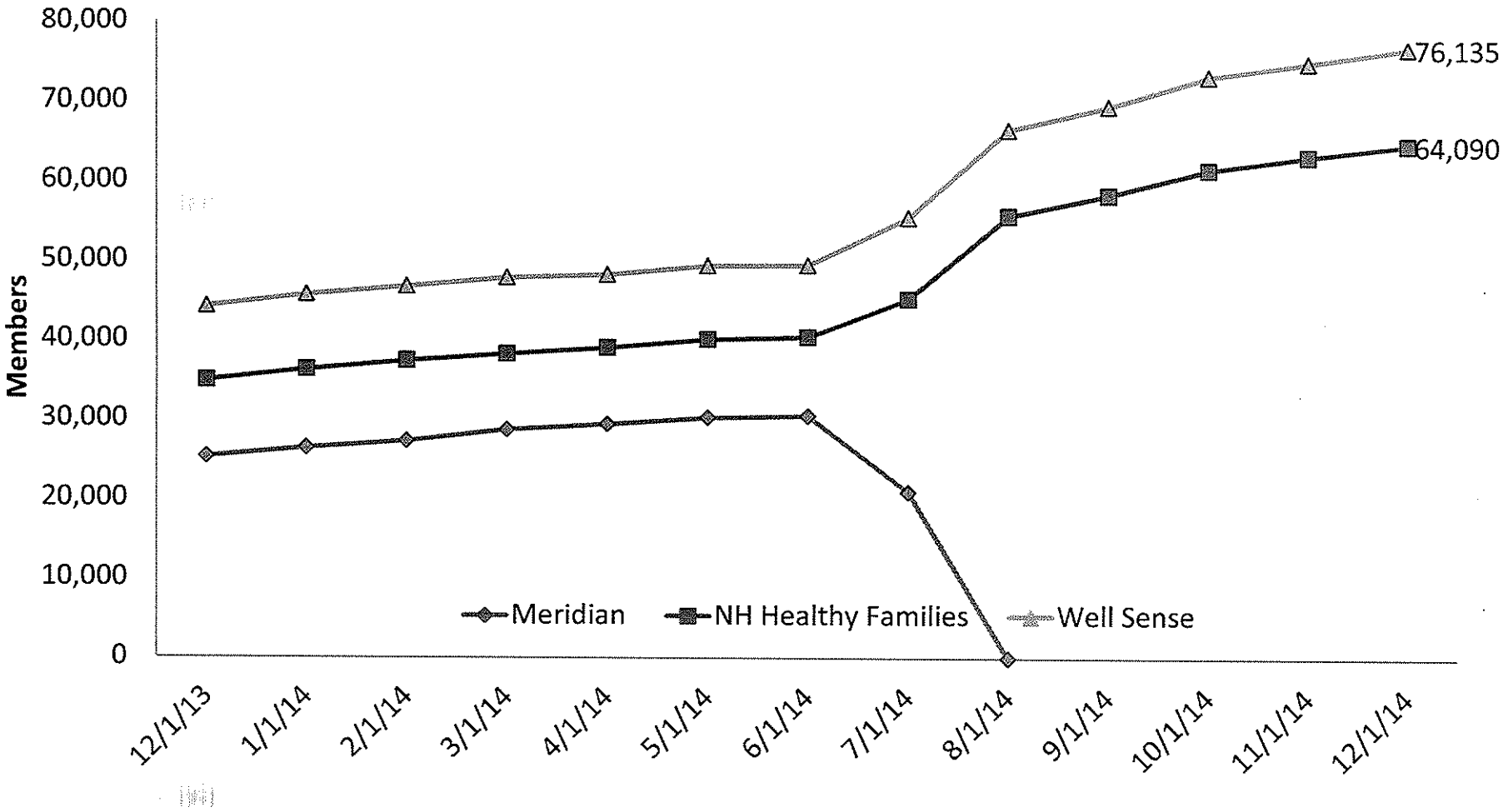
NH Medicaid Care Management Enrollment, 12/1/13 – 12/1/14



Note: Non-MCM Includes retroactive enrollment and excludes members who only have Medicare savings plans (e.g., QMB)

Source: NH MMIS as of 12/2/14 for most current period; Data subject to revision.

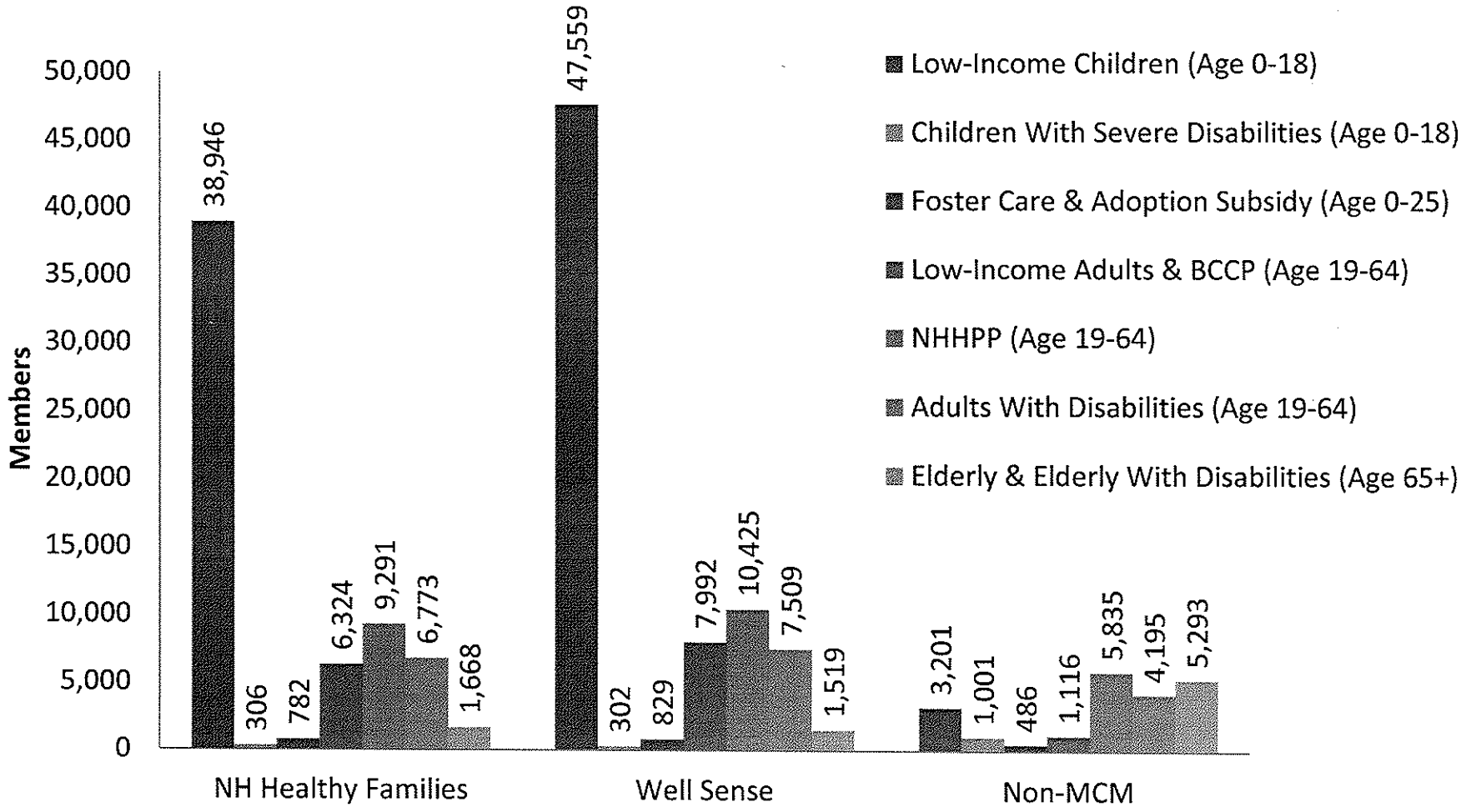
NH Medicaid Care Management Enrollment by Plan, 12/1/13 – 12/1/14



Note: Non-MCM Includes retroactive enrollment and excludes members who only have Medicare savings plans (e.g., QMB)

Source: NH MMIS as of 12/2/14 for most current period; Data subject to revision.

NH Medicaid Care Management by Eligibility Group, 12/1/14

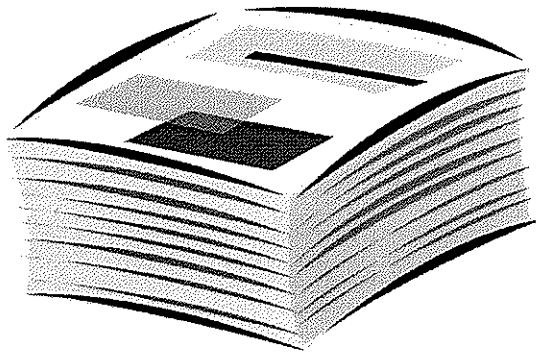


Source: NH MMIS as of 12/2/14; Data subject to revision.

NH HPP Update
As of 12/3/2014

- Total Recipients
  - 25,468
    - Over 11,017 are new to DHHS
    - Over 6,895 are new to NH HPP but have been clients in the past
- Benefit Plans
  - 23,527 are in the ABP (Alternative Benefit Plan)
  - 1,597 of Medically Frail are in the ABP
  - 344 of Medically Frail in standard Medicaid
- Care Management / HIPP
  - 92 Enrolled in HIPP
  - 611 are Potential HIPP
- Bridge
  - 10,828 are enrolled in WSHP
  - 9,552 are enrolled in NHHF
  - 4,385 are in Fee For Service/not yet enrolled in a plan

Key Performance Indicator Report



MCM Key Indicators

Metrics in the Key Indicators Report include:

- Access & Use of Care
- Customer Experience of Care
- Provider Service Experience
- Utilization Management
- Grievance & Appeals
- Preventative Care
- Chronic Medical Care
- Behavioral Health Care
- Substance Use Disorder Care
- General

Notable Results Summary 1

- Member requests for assistance accessing providers have fallen slightly. Falling requests for assistance would be expected after members have become familiar with accessing health care services. (Figure 1-1)

- The member to provider ratio for pediatricians has fallen. This ratio indicates that a greater number of pediatricians are available for the number of children in a MCO. (Figure 1-2)

- Figure 1-4: 25.6% of August transportation requests were not approved or not delivered. The most common reason transportation was not delivered, was that the ride was delivered in the following month, and not represented in the month it was requested. The Department is reviewing this measure with changes anticipated in early 2015. Rides that are not delivered will be categorized in part to include:
  - Ride cancelled by member;
  - Ride cancelled by the provider;
  - The member failed to show up for transportation, or
  - The provider of transportation failed to show up.

Notable Results Summary 2

- The number of emergency department visits has increased slightly. The Department will continue to monitor this measure. (Figure 1-6)

- For the data being reported (see Data Notes), member calls are being answered quickly and within MCM contract standards. (Figure 2-1 and 2-2)

- Figure 3-1 and 3-3: Clean provider claims are being paid, accurately and within MCM contract standards for timeliness.

- Provider clean claims are being paid, accurately and within MCM contract standards for timeliness. (Figure 3-1 through 3-4)

- Figure 3-4: The trend in answering provider calls within 30 seconds is downward indicating that a rising number of calls are being answered in more than 30 seconds. The Department will monitor this trend.

Notable Results Summary 3

- New Measures
  Figure 3-4: Claims Financial Accuracy (NEW)
  Figure 3-6: Provider Communications: Calls Abandoned (NEW)

- Provider calls are being handled well. The percentage of provider calls answered in 30 seconds is increasing indicating that provider calls are being answered quickly. (Figure 3-5 and 3-6)

- Urgent and routine service authorizations are being processed very close to MCM contract standards for timeliness. (Figures 4-1 and 4-2)

- The pharmacy service authorization processing rate continues to trend upward toward the contract standard. The Department will continue to monitor this indicator. (Figure 4-3)

Notable Results Summary 4

- Figure 4-4: An increase in the service authorizations, both approvals and denials, reflects the close of the initial 90 day transition into the MCM program. The health plans have begun to review services according to DHHS approved utilization management policies. An increase in denials may represent more appropriate utilization management.

- In Quarter 2, the health plans received 37,448 requests for **NEMT**. The percentage of denied requests for NEMT has decreased from Quarter 1 to Quarter 2. Initial denials for NEMT were in part due to a lack of adherence to prior authorization procedures. A reduction in denials may represent an increasing understanding in how to access services from the MCOs.
  - While the number of **therapies** reviewed increased from Quarter 1 to Quarter 2, the percentage of denied requests for therapies has remained essentially the same from Quarter 1 to Quarter 2.
  - The percentage of denied requests for **inpatient surgery** and **drugs** has increased. The Department will continue to monitor these trends.

- The number of grievances has increased slightly. (Figure 5-1)

The Technical Report is a regulatory requirement, produced by the EQRO, and will be delivered to NH the beginning of November. A presentation to the MCM Commission is planned for December 2014.

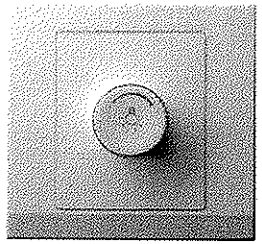
Step 2 Update

Concepts

Timeline

Key Changes

- Phase I and Phase II, Mandatory Enrollment and the integration of Choices for Independence Waiver and Nursing Facility services into Medicaid Care Management, have been combined.



- Step 2 will still be phased in.

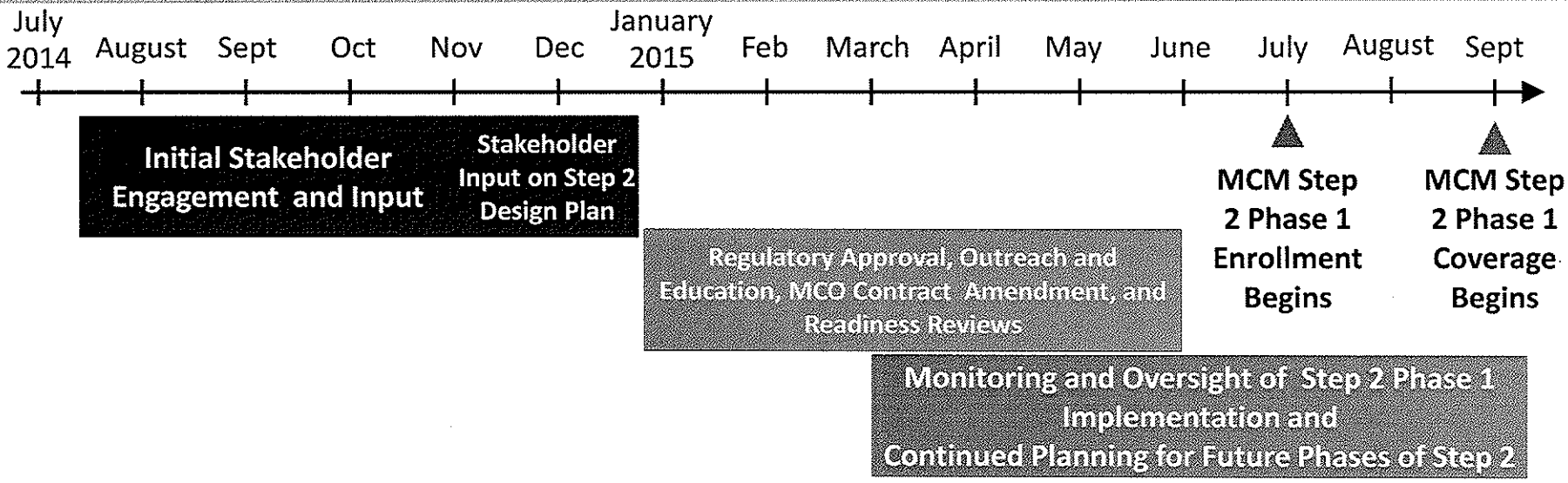
- Design considerations of managed long term services and supports, including provider contracting and payment, will evolve over time.

Revised Step 2 Timeline

- Earlier Timeline
  - Phase 1 Mandatory Populations by January 1, 2015
  - Phase 2 Choices For Independence (CFI) and Nursing Facility Services (NF) by April 1, 2015
  - Phase 3 Developmental Disabilities, Acquired Brain Disorder and In Home Support waivers will be implemented at a date to be determined.

- New Timeline
  - Phase 1 and Phase 2 combined
    - Enrollment begins July 1, 2015
    - Services begin September 1, 2015

Timeline



- **Stakeholder Input Process: July to December 2014**
  - Initial Stakeholder Engagement and Input completed in October 2014
  - Additional forums will be held to elicit stakeholder feedback on the Step 2 Design Considerations in November and December of 2014
- **Step 2 Phase 1:**
  - On **July 1, 2015**, require all populations to enroll with a health plan for their medical services, Choices for Independence Waiver and Nursing Facility services
  - On **September 1, 2015**, coverage with the health plan begins for medical services, Choices for Independence Waiver and Nursing Facility services

MCM Commission Step 2 Principles

- The Department has reviewed the vision, principles, and guidance recommended by the MCM Commission for implementing a Managed Long Term Services and Supports Program (MLTSS): Promoting Health, Wellness, Independence, and Self-Sufficiency.

- In response, the Department conducted a crosswalk of its actions taken and/or planned for Step 2 to each of the MCM Commission's recommended principles and principle implementation guidance.

- This crosswalk will evolve over time and be shared publically as the Department plans for and implements Step 2.

Next Steps

- We have scheduled 5 public sessions in December when we will present further detail for discussion. The presentation materials will be posted on the web before the first session. The dates are:
  - *December 1 in the Brown Building Auditorium at 1:30*
  - *December 2 at the Keene Public Library at 1:30*
  - ***December 8 at the Genesis Health Center in Lebanon at 1:00***
  - ***December 10 at the Littleton Area Senior Center at 12:45***
  - ***December 16 in the Brown Building Auditorium at 1:30***
- The feedback received throughout this period will be used as we continue to develop the design concepts.
- Another round of public sessions will be scheduled for early 2015.
- Information will be posted on the Department's Medicaid Care Management, Step 2 website http:www.dhhs.nh.gov/ombp/caremgt/step2.htm
- You can send e-mail concerning Step 2, Phase I, to the Bureau of Elderly and Adult Services at: beasmcmstep2@dhhs.state.nh.us

NH Health Protection Program
&
Other Updates

Premium Assistance Waiver Update

- Third phase of NHHPP program is Premium Assistance Program
  - Transition population from managed care coverage to Qualified Health Plans on FFM beginning on January 1, 2016 (per SB 413)
  - Final waiver application submitted and approved by Legislative Fiscal Committee on 11/10/14
  - Waiver submitted to CMS on 11/20/14
    - http://www.dhhs.nh.gov/pap-1115-waiver/
  - Waiver **must be approved by CMS by 3/31/15** for program to continue

1115 Waiver
Building Capacity for Transformation

- Application was submitted to CMS at the end of May 2014
- Revised Waiver is being finalized
- Public Session is on Friday, December 19th
  - Public Health Auditorium on Hazen Drive @ 12:30 to 2:00PM

Questions?